

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>001135</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/05/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KINGSTON RESIDENCE OF FORT WAYNE</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7515 WINCHESTER RD</b><br><b>FORT WAYNE, IN 46819</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| R 000   | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00161358.</p> <p>Complaint IN00161358 - Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey Dates: January 5, 2015</p> <p>Facility number: 001135<br/>Provider number: N/A<br/>AIM number: N/A</p> <p>Survey team:<br/>Angela Strass, RN</p> <p>Census bed type:<br/>Residential: 49<br/>Total: 49</p> <p>Census payor type:<br/>Other: 49<br/>Total: 49</p> <p>Sample: 3</p> <p>Kingston Residence of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00161358.</p> <p>Quality Review 01/06/15 by Lisa McColly</p> | R 000   |  |  |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE